Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #:	M4-08-5456-01
WALLS REGIONAL HOSPITAL 3255 W PIONEER PKWY ARLINGTON TX 76013-4620		
Respondent Name and Box #:		
State Office of Risk Management Box #: 45		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Understanding TWCC wants to move to a hospital reimbursement based on Medicare, we are asking for %-over-Medicare. We have found 125% of the Medicare allowable is fair and reasonable and has been accepted by most carriers."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $228.30
3. Hospital Bill
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "In review of the dispute packet submitted by the requestor Walls Regional Medical, the Office will maintain denial based on 089 – Please resubmit on the proper billing form.

Pursuant to Rule 134.401 (2)(D), General Information states All bills for professional services rendered by a health care practitioner shall be submitted on form TWCC-67, the standard HCFA form.

The requestor billed REV code 510 along with CPT codes 99213 and 99244 which are considered Evaluation and Management Service codes. There is not a technical component to these codes for reimbursement to a facility for the health care practitioner to use their rooms for evaluation and management services. The health care provider that provided these services billed the Office for these dates of service on a CMS 1500 (marked as exhibit I)

While the office reviewed the rationale the requestor submitted in the dispute packet, the requestor failed to provide evidence in the dispute packet to support their rationale for additional reimbursement."

Principle Documentation:

1. Response Package
2. Professional Bills

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
4/25/2007	151, 16, 250, 089, W4	99213	$51.16	$0.00
4/25/2008	151, 16, 250, 089, W4	99244	$177.14	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 151 – "Payment adjusted/undocumented services"
   - 250 – "Payment denied, Professional Fees"
   - 16 – "Not All Info Needed for Adjudication was Supplied"
   - 089 – "Please resubmit on the proper billing form"
   - W4 – "No additional payment allowed after review"

   With additional payment advice:
   - "All professional fees must be billed on a CMS-1500 for reconsideration."
2. This dispute relates to outpatient evaluation and management services provided in a hospital/clinic setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §134.401(b)(2)(D), effective August 1, 1997, 22 TexReg 6264, requires that "All bills for professional services rendered by a health care practitioner shall be submitted on form TWCC-67 [currently form DWC-67], the standard HCFA 1500 form." Review of the documentation submitted by the requestor finds that the services in dispute are evaluation and management services performed by a professional practitioner and for which no technical component is billable by a facility. Review of the medical bill finds that the provider did not submit the bill for the disputed professional services using a DWC-67/HCFA 1500 form. The requestor has therefore failed to submit the services to the carrier in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §134.401(b)(2)(D).
5. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include "a copy of all medical bill(s)"… "as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter"… Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier and as submitted for reconsideration. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(A).
6. Division rule at 28 TAC §133.307(c)(2)(C), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include "the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division"… Review of the documentation submitted by the requestor finds that the documentation does not support that the services in dispute were rendered on the dates of service listed on the requestor's *Table*. Review of the provider's bill finds that CPT code 99213 was performed on 4/27/2007 and CPT code 99244 was performed on 4/25/2007; however the requestor's Table lists CPT code 99213 as performed on "4.25.07" and CPT code 99244 as performed on "04.25.08". The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(C).
7. Division rule at 28 TAC §133.307(c)(2)(E), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute"… Review of the documentation submitted by the requestor finds that the requestor has not provided medical records to support the services in dispute. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(E).
8. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues"… Review

of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(F)(iii).

9. Division Rule at 28 TAC §133.307(c)(2)(G) , effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable". The requestor's position statement asserts that "Understanding TWCC wants to move to a hospital reimbursement based on Medicare, we are asking for %-over-Medicare. We have found 125% of the Medicare allowable is fair and reasonable and has been accepted by most carriers." Review of the requestor's position statement finds that the requestor did not discuss or explain how it determined that 125% of the Medicare rate would yield a fair and reasonable reimbursement. The requestor did not submit documentation to support requestor's assertion that the methodology has been accepted by most carriers. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011, or would ensure similar reimbursement to similar procedures provided in similar circumstances. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1. The request for additional reimbursement is not supported.

10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(C), §133.307(c)(2)(E), §133.307(c)(2)(F)(iii) and §133.307(c)(2)(G). Additionally, the Division concludes that the requestor failed to submit the bill for the disputed services to the carrier in the form and manner prescribed under Division rules at 28 Texas Administrative Code §134.401(b)(2)(D) . The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.